DEPARTMENT OF HEALTH & HUMAN
SERVICES Health Care Financing Administration

Center for Medicaid and State Operations 7500 Security Boulevard Baltimore, MD 21244-1850

January 6, 2000

Dear State Medicaid Director:

As part of an ongoing strategy to reform welfare, the Clinton Administration has fought to continue efforts to support low-income families, especially those trying to make the transition from welfare to self-sufficiency. As part of these efforts, it is critical that progress is made toward increasing the number of Americans with health insurance. The delinkage of Medicaid from cash assistance and declining welfare caseloads have created both challenges and opportunities for providing this support to working families.

To help policy-makers overcome these challenges, and realize the full potential of these opportunities, the President directed the Health Care Financing Administration (HCFA) to expand its efforts to provide technical assistance to States. In keeping with this directive, HCFA will issue a series of letters that will promote a better understanding of the flexibility, and the requirements, surrounding eligibility policy for Medicaid and the State Children's Health Insurance Program (SCHIP).

This letter, the first in the new series, follows-up and supercedes the August 30 letter from HCFA and the Administration for Children and Families (ACF) that clarified the expiration dates for State allotments from the $500 million dollar fund created as authorized under section 1931(h) of the Social Security Act (the Act). As you may recall, President Clinton and the Congress established the $500 million fund to help States improve their Medicaid program enrollment and eligibility determination processes in light of welfare reform. The purpose of this letter is to inform you of recent legislation signed by President Clinton that affects the expiration dates for the fund, to provide further information about the allowable uses of the allotments from it, and to urge you to take advantage of these funds.

The bipartisan Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113), enacted on November 29, 1999, removed the national and State specific

expiration dates for the availability of allotments for States expenditures under the $500 million fund. This change is critical in giving States the flexibility to enroll families and children that are eligible for Medicaid. Prior to enactment of P.L. 106-113, authorization for the $500 million fund expired on September 30, 2000. In addition, State allotments from the fund were only available to match allowable expenditures that were incurred during the first 12 quarters of each State's Temporary Assistance for Needy Families (TANF) program. Now, States may take the time they need to assure that these funds are spent on necessary and appropriate activities that will

implement delinking effectively and promote the enrollment of eligible children and families. Because the repeal of the Aid to Families with Dependent Children (AFDC) program and its replacement with TANF resulted in the delinkage of Medicaid from welfare eligibility, new rules and systems and outreach needs have arisen in Medicaid.

In the May 14, 1997 Federal Register notice implementing the $500 million fund provisions, we emphasized the importance of certain activities, such as outreach and education, which included a general category of "other activities identified by States and approved by the Secretary." As referenced in the Federal Register notice and HCFA's letter dated May 14, 1997, there are a number of appropriate uses for the $500 million funds, including: eligibility determinations and re-determinations that arise as a result of delinking; beneficiary educational activities; the production and airing of public service announcements; outstationing, hiring and training eligibility workers; designing, printing, and distributing new eligibility forms; identification of TANF recipients and applicants who are at risk of either losing their Medicaid or not being enrolled in Medicaid; and assuring access to Medicaid for low-income families who are not eligible or applying for TANF but are eligible for Medicaid under the section 1931 eligibility category.

There have been a number of questions raised about the uses of this fund and the proper claiming procedures. We enclose a copy of these questions along with our answers. We hope this proves helpful as you submit claims under your allotment of the $500 million fund.

Again, I strongly encourage you to take advantage of the support offered by the $500 million fund and to enroll all eligible families in Medicaid and SCHIP. If you have additional questions, please contact your HCFA Regional Administrator.

Sincerely,

/s/

Timothy M.
Westmoreland
Director

Enclosure

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge Director, Health Policy Unit American Public Human Services Association

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CLAIMING REIMBURSEMENT UNDER THE $500 MILLION FUND FOR TANF-MEDICAID OUTREACH

Q1: What can this fund be used for?

A: This fund can be used for a wide range of activities related to enrollment systems and outreach for individuals who could possibly be eligible under the Medicaid eligibility group for low income families established by section 1931, even if the individuals are ultimately not enrolled through 1931.

The delinking of receipt of cash assistance as the primary basis for Medicaid eligibility represented a substantive change in the categorical basis of the Medicaid program that required States to alter their approach to Medicaid eligibility determinations. Due to this change, many activities conducted by States (such as certain eligibility determinations, conducting outreach, revising notices, and modifying eligibility systems) may be primarily related to implementation of the section 1931 provisions. Therefore, when a State performs such activities under --or related to-- the 1931 provision, the State could consider the full cost of that activity as clearly attributable to the enactment of section 1931 of the Act. As such, a broad range of activities, such as beneficiary education, public service announcements and outstationing activities, can be considered attributable to the enactment of section 1931 and claimed under the $500 million fund. Furthermore, administrative costs incurred in support of these activities could also be claimable. Such support costs include supervision of the employees performing the activities and the physical moves of personnel related to the 1931 fund, but only as such costs would otherwise be claimable under Medicaid statute at section 1903(a)(7) of the Act.

Q2: Can States claim funds for eligibility determinations and redeterminations?

A: Yes. When determining eligibility of individuals who could possibly be eligible under the Medicaid

eligibility group for low income families established by section 1931, such activities would be reimbursable under the 1931 fund to the extent that the eligibility determination costs would not have been incurred but for the enactment of section 1931. For example, eligibility determinations under section 1931 for families not receiving cash assistance (medical assistance only) are new activities required by delinking. The cost of eligibility determinations and redeterminations for these families could be claimed under the $500 million fund. Note, the costs of eligibility activities that were conducted prior to the enactment of section 1931, and which are merely continued, could not be assumed to relate primarily to section 1931.

In assessing the Medicaid eligibility of individuals under the section 1931 provision, States will find that not all such individuals will ultimately qualify under that provision. However, when the primary goal of the eligibility process is the determination of the individuals' Medicaid eligibility with respect to the provisions of section 1931, the costs of the entire process related to the Medicaid

eligibility determination would be considered appropriate to be claimed under the $500 million fund. The eligibility determination process includes the redetermination process. Note, the costs of determining eligibility under another Federal or State assistance program, other than the Medicaid program, are not claimable to the Medicaid program. The costs of eligibility determinations for these other programs should be claimed under such programs. In this regard, the costs of the entire eligibility process would need to be allocated between Medicaid and the other programs in accordance with provisions of OMB Circular A-87.

Q3: Can States claim funds spent on outreach activities?

A: Yes. It is important that States educate families about the availability of Medicaid coverage and inform them that Medicaid eligibility is not tied to the receipt of TANF, and about transitional Medicaid. Therefore, States should conduct outreach activities primarily intended for individuals who may be eligible under section 1931. We recognize that it is neither administratively efficient nor practical, with respect to such outreach activities, to distinguish between activities resulting in eligibility determinations under Section 1931 and activities related to Medicaid eligibility under other statutory authorities. Therefore, where the outreach activities are primarily intended to address eligibility under section 1931, unless there are specific indications to the contrary, the entire costs of such outreach activities would be claimable under the $500 million fund, even if the activities have the effect of increasing enrollment for other eligibility categories.

Q4: Are funds available for previously incurred expenditures?

A: Yes. However, the elimination of the sunset on these funds now makes it possible for states to move forward to devise new systems and strategies to assure that delinking is implemented properly and to develop other effective enrollment strategies. These funds are intended to help States assure that systems and strategies are in place so that eligible families receive the assistance to which they are entitled.

States may claim costs for allowable activities during the period beginning with the effective date of

their TANF programs, including those for which they may have already made claims for Federal matching at the standard Federal matching rate (for example, 50 percent), to identify and properly claim costs of allowable activities. Note, States' claims for Federal matching funds under the $500 million fund must still meet the 2-year timely filing requirements for submission of claims; although claims that have already been submitted in the past but were claimed and matched at the regular Federal matching rate have already met such requirements. To claim at the enhanced Federal matching rate available under the $500 million fund, a State would need to identify and reclaim such expenditures at the higher matching rate. States should work with their respective HCFA Regional Offices to review and make these adjustments, as appropriate.

Q5: When must the funds claimed under the $500 million be spent?

A: Section 602 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113) which was enacted on November 29, 1999, removed the national and State specific expiration dates for the availability of allotments for States expenditures under the $500 million fund. Therefore, each State's allotment of the $500 million is available until expended by the State.

HCFA/CMSO: January 2000

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